Emergency contraception – lack of awareness among women presenting for termination of pregnancy

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To the Editor: Emergency contraception (EC) when used after unprotected intercourse, within defined time limits, can reduce the risk of an unwanted pregnancy. In South Africa EC is available free of charge in public sector clinics and over the counter, i.e. without prescription, in private sector pharmacies. Termination of pregnancy services have been legal in SA since 1996 and have resulted in a marked decrease in abortion-related morbidity and mortality.[1] However, abortion services remain inaccessible for many women because of stigma, provider resistance and lack of trained providers and designated facilities.[2] An increased use of EC could lead to a reduction in both legal and illegal abortion. In this article we report on the awareness and use of EC among women presenting for a termination of pregnancy.

This study was part of a broader cross-sectional study, conducted in 2004, on the timing and patterns of pregnancy confirmation in the Cape Town area.[3] Consecutive consenting women booking for first- and second-trimester termination of pregnancy (TOP) at public sector health facilities in two urban districts were interviewed using a standardised, pre-tested questionnaire. Data analysis was conducted using Stat 9.0 (Stata Corporation, College Station, Texas, USA). Ethical approval was granted by the Ethics Review Committee at the University of Cape Town.

A total of 164 women participated in the study – 82 women presenting for first-trimester and 82 for second-trimester terminations. The participants were young women (median age 24 years; range 15 - 39). Most participants (68%) spoke Xhosa as their main language. Forty-three per cent of the participants had Grade 12 or higher level of education. Sixty-three per cent were married or in a stable relationship.

The majority of women (68%) had had previous pregnancies. Twenty-one per cent reported that they were using a method of contraception when they fell pregnant, namely the condom (53%), the pill (35%) and the injection (12%). All women reported that the current pregnancy was unplanned.

Overall 35.4% of clients had heard of emergency contraception: 40.2 % of first-trimester and 30.5% of second-trimester clients ($p = 0.322$). Few women ($N = 12$) had ever used EC. Of those who used EC, 7 had done so once and 5 more than once. Among those who ever used EC 4 had obtained EC from a public clinic and 8 from a pharmacy. For this current pregnancy, 9 clients had considered and 7 had actually used EC. Women who were younger than 20 years ($p = 0.033$), more educated ($p = 0.019$) and spoke either English or Afrikaans as opposed to Xhosa ($p = 0.014$) were more likely to have heard of EC. There was no association between condom use and awareness of EC.

EC awareness reported in our study was lower than that recorded in studies among clients awaiting TOP in other countries.[4,5] The awareness level in our study was similar to that reported previously for the urban Western Cape province.[6] However, the latter study was conducted among women attending public sector clinics for any primary level service. Our study was conducted among women attending TOP services, all of whom mentioned that their current pregnancy was unplanned. Furthermore the majority of the women in our study had had previous contact with reproductive health services, either for contraceptive services or during a previous pregnancy. Clearly there have been missed opportunities for improving EC knowledge and use among clients attending reproductive health services.

Our finding that younger and more educated women had greater awareness of EC is consistent with other investigations. Further investigation is needed to better understand why women who spoke English or Afrikaans were more aware of EC than those who spoke Xhosa. EC is increasingly being advocated as a back-up method for condom failure. Disappointingly, we found no association between awareness of EC and condom use.

A limitation of our study is that it was a relatively small survey conducted in one part of the country. Furthermore we did not explore the level of client EC knowledge. Our study indicates a worrying lack of awareness of EC among women attending TOP services.

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Rape survivors and the provision of HIV post-exposure prophylaxis

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To the Editor: Rape and HIV/AIDS are two scourges of epidemic proportion in South Africa, which is known for high levels of sexual violence and one of the fastest-growing HIV epidemics in the world.[1] While the link between rape and long-term physical and mental health problems is well established,[2] the vast majority of rapes go unreported and only a small proportion of women attend health care services after rape, with many believing that their actions will not lead to punishment for the perpetrator.[3] Another factor that may worsen matters even further is the latest version of the original bill on sexual offences (Criminal Law (Sexual Offences) Amendment Bill) passed in 2003. The latest version of the Bill states that the provision of post-exposure prophylaxis (PEP) is dependent on the 'victim' laying a charge.[4] This is likely to have a major negative impact on rape survivors receiving PEP within 72 hours and may impede the ability of medical and police officials to obtain medical evidence that is crucial for the successful prosecution of the perpetrator. Furthermore, the Bill does away with measures to provide for the comprehensive management, care and treatment of rape survivors and the omission of these measures is arguably dismissive of the needs of rape survivors. Another issue of concern is that women who do lay a charge and attend a health care service after rape do not optimally access and utilise the range of services available. Many primary and secondary level services in this country provide HIV testing and counselling, PEP, treatment of sexually transmitted infections, pregnancy testing and prevention, forensic examination and treatment of injuries. Health services providing the spectrum of post-rape care have an important role to play in changing the horrendous image of rape and HIV/AIDS and more particularly in fulfilling the needs of rape survivors. However, compliance and follow-up remains a major challenge at ground level.

Some of the well-known public health services providing post-rape care in the Western Cape are the Karl Bremer Rape Centre, Groote Schuur Hospital, and the Thuthuzela Rape Centre established at G F Jooste Hospital. We conducted a retrospective analysis of rape survivors presenting to Karl Bremer Rape Centre over a 6-month period (January - June 2005). Three hundred and sixty-three confirmed cases of female rape were identified through chart review, with a mean age of 23.2 years (SD = 10.1). The highest number of patient visits was recorded on Saturdays and Sundays and it may therefore be assumed that the frequency of rape specifically increases over weekends. There was clinical evidence of alcohol use in more than a quarter of rape survivors (N = 102) and clinical evidence of drugs in about 2% (N = 7). Notably, in 50 reported cases (14%) 2 or more perpetrators were involved, with the number of perpetrators ranging from 1 to 8. The vast majority of perpetrators were not known to the survivor (N = 112; 31%), while in 4% of cases (N = 14) a familial relationship (the rapist being a parent, sibling, cousin, step-sibling, uncle) existed. More than a third of women had sustained genital (N = 128; 35%) or other physical injuries (N = 93; 26%). Approximately 13% (N = 47) tested HIV positive (on the initial Rapid Test) and 18 patients (5%) tested positive for pregnancy. Perpetrators used a condom in only 6% of cases (N = 22). Only 12 women (3.4%) reported for a follow-up assessment at the clinic within a 3-month period.

The findings are significant when considering the potential impact of PEP provision and post-rape care on health services, as well as on police and related services.[5] The involvement of multiple perpetrators in about a quarter of cases is not

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insubstantial when assessing the potential impact of PEP, since rape by multiple perpetrators potentially means multiple HIV-infected perpetrators.[5] Involvement of multiple perpetrators (particularly in the context of gang rape) is likely to be associated with greater health care needs (physical and emotional) on the part of survivors. We need to be cognisant of this if we are aiming to deliver efficient post-rape care.

Multidisciplinary care services with a holistic approach, such as the Karl Bremer Rape Centre, play a crucial role in addressing the various needs of rape survivors. A recent South African study on women's experiences of, and preferences for, services after rape clearly indicated that rape survivors have a need for holistic post-rape care.[6] The study showed that women particularly valued the availability of HIV prophylaxis and a sensitive health care provider who could provide counselling, and that women were willing to travel further to clinics for counselling, rigorous examination and HIV prophylaxis. That said, the long-term success of health services in preventing HIV/AIDS and in fulfilling the specific needs of rape survivors may be undermined by a lack of research on the effectiveness of PEP following sexual assault. Research on the latter needs to be done together with ongoing efforts to operationalise and evaluate what is currently available and applicable within the South African context.[5] Empirical data on the efficacy of PEP will essentially contribute to the provision of more optimal services for rape survivors. For many rape survivors in South Africa, rape means a death sentence. More efficient services as well as increased conviction rates for perpetrators are concrete ways of addressing criminal sexual assault and will ultimately go a long way toward preventing new HIV infections.[7]

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